TABLE OF CONTENTS

CHAPTER ELEVEN

EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT FOR INDIVIDUALS UNDER 21

Chapter 11. Early and Periodic Screening, Diagnosis, and Treatment for Individuals Under Twenty-one (21)

Rule No. 560-X-11-.01. Early and Periodic Screening, Diagnosis, and Treatment for Individuals Under Twenty-one (21) - General.

(1) Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) of certain eligible individuals under age twenty-one (21) is a mandatory service of the Medicaid Program intended by Congress to direct attention to the importance of preventive health services and early detection and treatment of disease in children eligible for medical assistance.

(2) The Alabama Medicaid Agency:

(a) Will provide for a combination of written and oral methods designed to effectively inform all EPSDT eligible individuals (or their families) about the EPSDT program. Generally, this information will be provided within 60 days of the individual's initial Medicaid eligibility determination and in the case of families which have not utilized EPSDT services, annually thereafter.

(b) Will using clear and nontechnical language, provide information about the following: the benefits of preventive health care, the services available under the EPSDT program, and how to obtain these services.

(c) Will inform recipients that the services provided under the EPSDT program are without cost to eligible individuals under 21 years of age. Exception: Copayment is required of individuals from eighteen (18) to under twenty-one (21).

(d) Will provide other medically necessary health care, diagnostic, treatment and/or other measures described in section 1905(a) of Title XIX to correct or ameliorate defects, physical and mental illnesses and conditions discovered during a screening.

(e) Will inform individuals that necessary transportation and scheduling assistance are available upon request.

(f) Will provide an extensive outreach program for EPSDT recipients.

(g) In conjunction with the Alabama Department of Human Resources, will jointly develop an agreement covering the responsibilities of the county Departments of Human Resources, county Health Departments and other screening providers for EPSDT.

Authority: Title XIX, Social Security Act; State Plan; 42 C.F.R. Section 441.56; OBRA '89-Section 6403. Rule effective October 1, 1982. Rule amended June 8, 1985. ER effective December 1, 1986. Effective date of this amendment March 12, 1987. ER effective October 1, 1990. Amended February 13, 1991. ER effective December 1, 1992. Effective date of this amendment January 13, 1993.

Rule No. 560-X-11-.02. Major Components of EPSDT.

(1) Early

As early as possible in the life of a child already Medicaid eligible or as soon as possible after a person's eligibility is established, if he or she is under twenty-one (21) years of age;

(2) Periodic

At intervals established by Medicaid to assure that disease or disability is not incipient or present in persons eligible for the EPSDT services;

(3) Screening

Assessment of the physical and mental health of all persons under twenty-one (21) years of age who are Medicaid eligible.

(4) Diagnosis

Further study of persons to determine the nature or cause of disease or abnormality to provide a frame of reference for treatment;

(5) Treatment

Any Treatment available under the Alabama Medicaid Program including eyeglasses, hearing aids and other necessary health care, diagnostic services to correct or ameliorate defects, physical and mental illnesses and conditions discovered during a screening.

Authority: Title XIX, Social Security Act; State Plan; 42 C.F.R. Section 441.50; OBRA '89-Section 6403. Rule effective October 1, 1982. Rule amended June 8, 1985. ER effective December 1, 1986. Effective date of this amendment March 12, 1987. ER effective October 1, 1990. Effective date of this amendment February 13, 1991.

Rule No. 560-X-11-.03. Eligibility.

(1) All persons under twenty-one (21) years of age except SOBRA adult eligibles who have been certified as being eligible for Medicaid are eligible for the EPSDT program.

(2) Alabama Medicaid Agency assigns Medicaid identification numbers and issues plastic Medicaid eligibility cards to persons eligible for benefits.

(3) In providing services and filing a claim for medical payment, it is required that a person be eligible in the month in which the service is rendered.

(4) Alabama Medicaid Agency Administrative Code, Chapter One, General, contains information about the identification of Medicaid recipients.

Authority: Title XIX, Social Security Act; State Plan; 42 C.F.R. Section 441.50; OBRA '89-Section 6403. Rule effective October 1, 1982. Rule amended June 8, 1985. ER effective December 1, 1986. Effective date of this amendment March 12, 1987. ER

effective October 1, 1990. Amended February 13, 1991. ER effective December 1, 1992. Effective date of this amendment January 13, 1993.

Rule No. 560-X-11-.04. EPSDT Manual.

(1) A manual on the EPSDT Program setting forth in detail the elements of the physical examination, instructions for completion of forms, processes and procedures to follow in administration of local programs and billing instructions will be provided to each EPSDT provider. Failure to follow the procedures and requirements as outlined in the manual may result in recoupment of the funds paid to the provider.

(2) EPSDT School-Based screening providers must follow the Protocols and Procedures for EPSDT School-Based services in addition to the EPSDT Manual. Failure to comply may result in recoupment of the funds paid to the provider.

Authority: Title XIX, Social Security Act; State Plan; 42 C.F.R. Section 441.56(d). Rule effective October 1, 1982. ER effective December 1, 1986. Amended March 12, 1987. ER effective October 1, 1990. Amended February 13, 1991. Effective date of this amendment May 11, 1995.

Rule No. 560-X-11-.05. Providers of Screening Services.

(1) In-state and borderline out-of-state (within 30-mile radius of state line) health care agencies and physicians wishing to participate in the EPSDT Program may request enrollment information from the Alabama Medicaid Agency. Exception: The Fiscal Agent will be responsible for enrolling any Title XVIII (Medicare) providers that wish to enroll as a QMB-only provider.

(2) All providers of screening services must enter into an agreement with Alabama Medicaid Agency to participate in the EPSDT Program as a screening provider. Exception: QMB-only providers. Each off-site location will require a separate application, a separate contract, and will be assigned a provider number distinct from any other the provider may have with Medicaid.

(3) All health care agencies enrolled shall be under the direction of a duly-licensed physician, a currently licensed registered nurse, or a certified nurse practitioner who shall be responsible for assuring that requirements of participation are met and that the procedures established by the Medicaid program are carried out.

(4) Screening programs conducted under the direction of a registered nurse or certified nurse practitioner must have a licensed physician acting as medical consultant.

(5) EPSDT services may be offered by School-Based screening providers.

Author: Lynn Sharp, Associate Director, Policy Development, Medical Services Division
Statutory Authority: Title XIX, Social Security Act; State Plan; 42 C.F.R. Section 400.203, Section 441.56. Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360). OBRA '89-Section 6403.
History: Rule effective October 1, 1982, May 9, 1984, July 9, 1984, December 1, 1986, March 12, 1987, July 13, 1989, October 1, 1990, February 13, 1991, May 11, 1995. Amended: Filed February 19, 1999; effective May 10, 1999.

Rule No. 560-X-11-.06. Procedures and Tests in the Screening Examination.

(1) The Agency will establish specific health evaluation procedures to be used by screening providers. These procedures and tests will be fully described in the Screening Provider Manual.

(2) All procedures and tests included in the Screening Provider Manual must be carried out on each person screened and must be recorded in the case history of the individual.

(3) Where it is not possible to carry out all procedures and tests, this fact must be recorded in the case history of the individual, including the reason such procedure or test was not carried out.

(4) Requirements in this paragraph are subject to federal and state audits and documentation in the records will be examined in on-site visits from time to time. Failure to meet these requirements may result in recoupment of the funds paid to the provider.

Authority: Title XIX, Social Security Act; State Plan; 42 C.F.R. Section 441.56(d); OBRA '89-Section 6403. Rule effective October 1, 1982. ER effective December 1, 1986. Effective date of this amendment March 12, 1987. ER effective October 1, 1990. Effective date of this amendment February 13, 1991.

Rule No. 560-X-11-.07. Screening Schedule.

(1) The Agency will establish a distinct periodicity schedule for screening services, after consultation with recognized medical organizations involved in child health care. This schedule will be published in the Screening Provider Manual.

(2) Periodic screening services will be provided at intervals that meet reasonable standards of medical practice in accordance with those described for well-child care in the Guidelines for Health Supervision of American Academy of Pediatrics.

(3) Interperiodic screenings are covered when medically necessary to determine the existence of suspected physical or mental illnesses or conditions.

(4) An EPSDT Intensive Developmental Diagnostic Assessment is a multidisciplinary comprehensive screening limited to infants 0 to under two years of age,

and is also limited to two per recipient per lifetime. These screenings are in addition to the routine periodic screenings and must be performed by a qualified EPSDT Intensive Developmental Diagnostic Assessment Screening provider, as approved and enrolled by Medicaid.

Authority: Title XIX, Social Security Act; State Plan; 42 C.F.R. Section 441.50; OBRA '89-Section 6403. Rule effective October 1, 1982. Amended July 9, 1984, June 8, 1985. ER effective October 1, 1986. Amended October 11, 1986. ER effective December 1, 1986. Amended March 12, 1987. ER effective November 7, 1988. Emergency Rule effective October 1, 1989. ER effective October 1, 1990. Amended February 13, 1991. Effective date of this amendment January 13, 1993.

Rule No. 560-X-11-.08. Consultation Services to Screening Providers.

(1) Professional nursing staff of the Alabama Medicaid Agency will provide assistance to any screening provider who requests it.

(2) The Medicaid staff will assist providers and County Departments of Human Resources with problems in local administration of the EPSDT Program upon request, or as need is identified in on-site visits to screening providers.

Authority: Title XIX, Social Security Act; State Plan; 42 C.F.R. Section 441.61. Rule effective October 1, 1982. ER effective December 1, 1986. Effective date of this amendment March 12, 1987. ER effective October 1, 1990. Effective date of this amendment February 13, 1991.

Rule No. 560-X-11-.09. EPSDT Referral for Services.

(1) All participating EPSDT providers will complete the EPSDT Referral for Services form for each individual provider to whom a person is being referred to for further diagnosis and/or treatment.

(2) When a screening provider refers a person to a Medicaid participating provider for diagnosis and/or treatment, all treatment services will be considered for reimbursement, above current limitations. However, the services rendered must be medically necessary to treat or ameliorate a condition or diagnosis identified in a screen.

(3) The referring provider must document within the patient's medical history or physical examination portion of the medical record the condition(s) identified during an EPSDT Screening examination which requires a referral. Notation of the condition on the EPSDT referral form alone will not be considered sufficient documentation. Medicaid has the right to recoup payment for the screening service from the referring provider, when a referral is made for a condition not documented in the medical history or physical examination portion of the medical record.

(4) Alabama Medicaid Agency Administrative Code, Chapter One, General, contains information about extended benefits as a result of an EPSDT screening and referral.

Authority: Title XIX, Social Security Act; State Plan; 42 C.F.R. Section 441.61; OBRA '89-Section 6403. Rule effective October 1, 1982. Emergency Rule effective December 1, 1986. Amended March 12, 1987. Emergency Rule effective October 1, 1990. Amended February 13, 1991. Effective date of this amendment July 11, 1995.

Rule No. 560-X-11-.10. Reimbursement.

(1) Governmental screening providers (including physicians) will be paid on a negotiated rate basis which will not exceed their actual costs. Non-governmental screening providers will be paid their usual and customary charge which is not to exceed the maximum allowable rate established by Medicaid.

(2) In screening a recipient, the provider's contract screening cost will cover the following services: unclothed physical examination; vital signs; heights and weights; family, medical, mental health and immunization histories, vision and hearing testing; developmental assessment including anticipatory guidance and nutritional assessment; hematocrits or hemoglobins; urine testing for protein and glucose; and follow-up of all referred conditions to insure whether or not treatment has been initiated.

(3) Providers may submit claims for immunization, TB skin test and treatment on the day of screening. These charges submitted on the HCFA-1500 form are in addition to the screening charge, but no office visit should be charged at that time.

Authority: Title XIX, Social Security Act; State Plan; 42 C.F.R. Section 441.50; OBRA '89-Section 6403. Rule effective October 1, 1982. Rule amended July 9, 1984. ER effective December 1, 1986. Effective date of this amendment March 12, 1987. ER effective October 1, 1990. Effective date of this amendment February 13, 1991.

Rule No. 560-X-11-.11. Consent for Health Services for Certain Minors and Others.

(1) Consent for health services for certain minors, and others will be governed by Code of Alabama, 1975, Title 22, Chapter 8.

(2) All consent forms must be signed by the parent or legal guardian except for clients fourteen (14) years and older who may sign for themselves.

Authority: Title XIX, Social Security Act; State Plan; 42 C.F.R. Section 441.56. Code of Alabama, 1975. Rule effective October 1, 1982. ER effective December 1, 1986. Effective date of this amendment March 12, 1987. ER effective October 1, 1990. Effective date of this amendment February 13, 1991.

Rule No. 560-X-11-.12. Notification Procedures for Handicapped Individuals Eligible for EPSDT.

(1) Hearing Impaired:

(a) Each recipient will be notified of services during a face-to-face verbal interview at which time an individual who communicates via sign language or other methods will be present if needed to pass information to the recipient.

(b) Written information will to be given to both the recipient and the individual who communicates with him.

(2) Visually Impaired:

(a) Each recipient will be notified of services during a face-to-face interview, during which time an individual who can communicate with the recipient will be present, if needed, to pass information to him.

(b) The recipient will be given information in Braille. Written information will be given to the individual who communicates with the recipient as well.

(3) Those Who Do Not Speak English:

(a) Each recipient will be notified of services during a face-to-face interview at which time an individual who communicates in the recipient's language will be present for interpretation.

(b) Written materials in Thai, Laotian, Cambodian, and Vietnamese languages are available and will given to recipients who speak these languages and may also be given to the interpreter for those who are illiterate.

Authority: Title XIX, Social Security Act; State Plan; 42 C.F.R. Section 441.56. Rule effective October 1, 1982. ER effective December 1, 1986. Effective date of this amendment March 12, 1987. ER effective October 1, 1990. Effective date of this amendment February 13, 1991.

Rule No. 560-X-11-.13. State Laboratory Services.

(1) Arrangements have been made with the Clinical Laboratory Administration to have the State Laboratory examine blood specimens for sickle cell anemia and other abnormal hemoglobins, stool specimens for ova and parasites, and scotch tape preparations for pinworms. VDRL, G.C. cultures, throat culture and blood lead level may also be done at no cost to the provider.

(2) Payment is made by Medicaid to the laboratories who have been enrolled as Medicaid providers for examination of specimens submitted by screening agencies and physicians.

(3) Care should be taken to see that the correct Medicaid number is entered on the label or form accompanying such specimens.

Authority: Title XIX, Social Security Act; State Plan; 42 C.F.R. Section 441.61; OBRA '89-Section 6403. Rule effective October 1, 1982. ER effective December 1, 1986.

Effective date of this amendment March 12, 1987. ER effective October 1, 1990. Effective date of this amendment February 13, 1991.

Rule No. 560-X-11-.14 EPSDT Referred Service Providers

(1) OBRA '89 requires that medically necessary health care, diagnosis, treatment and/or other measures described in Section 1905(a) of the Social Security Act be covered under Medicaid if identified in an EPSDT screening whether or not such services are covered in the State Plan. If services are not ordinarily provided as a Medicaid benefit for children under age 21, the providers of the service will be enrolled to provide "EPSDT only" referred care. An EPSDT referral form must be maintained by the provider for services provided as a result of a screening.

(a) EPSDT-only providers include: physical therapists, occupational therapists, speech therapists, chiropractors, podiatrists, psychologists, private duty nurses, air transportation, and environmental lead investigators.

(b) Enrollment: Instate and borderline out-of-state (within 30 mile radius of the Alabama state line) are eligible to enroll as EPSDT-only providers.

(c) Documentation: EPSDT-only services are covered by Alabama Medicaid when medically necessary and when done to correct or ameliorate a defect, physical or mental illness or other conditions identified during an EPSDT Screening Exam. EPSDT-only providers must develop a plan of treatment and have it readily available at all times for review in the recipient's medical record. The plan of treatment should contain but is not limited to the following information:

1. Recipient's name,
2. Recipient's current Medicaid number,
3. Date of EPSDT Screening,
4. Referring physician's name,
5. Diagnosis(es),
6. Date of onset or acute exacerbation, if applicable,
7. Type of surgery performed, if applicable,
8. Date of surgery, if applicable,
9. Functional status prior to treatment and expected status after treatment, if applicable,
10. Frequency and duration of treatment, if applicable,
11. Modalities, if applicable, and
12. For ulcers, the location, size and depth should be documented, if applicable.

(d) Retrospective Review: Medicaid's Surveillance and Utilization Review Program will review medical records retrospectively to determine the appropriateness of the service rendered. Medicaid may discontinue and/or recoup payment for the treatment or service if any of the following circumstances have occurred:

1. An EPSDT screening was not performed,
2. The condition/diagnosis noted on the EPSDT referral form does not relate to the treatment performed, and

3. The EPSDT screening form is not valid. (EPSDT screening referral forms are valid only for the time specified by the referring provider or up to a maximum of twelve (12) months).

(2) Qualifications For EPSDT-only Providers:

(a) Physical Therapists (PT) - A qualified PT must be licensed by the Alabama Board of Physical Therapy. Services provided must be ordered by a physician for an identified condition(s) noted during the EPSDT screening exam and provided by or under the supervision of a qualified physical therapist. Group physical therapy is covered only for codes specified as such in the Physical Therapy Billing Manual. Only procedure codes identified in the Medicaid Physical Therapy Billing Manual are reimbursable. Some codes may require attainment of prior authorization before services are rendered. Recreational and leisure type activities such as movies, bowling, skating, etc. are not covered by Medicaid.

1. Physical therapy may be provided by a PT assistant who practices under the direction of a licensed PT. Assistants may perform treatment procedures as delegated by the PT but may not initiate or alter a treatment plan. PT assistants must be licensed by the Alabama Board of Physical Therapy and must be an employee of the supervising PT in order for the PT to bill for services. The PT must oversee the assistants' activities on a frequent, regularly scheduled basis. Scheduled visits to supervise care provided by the assistant must be documented and signed by the PT at a minimum every 6th visit.

2. Physical therapy aides who are employed by the PT may perform only routine treatment procedures as allowed by State law and only under direct, on-site supervision of the licensed PT. Care rendered by a PT aide shall not be held out as and shall not be charged as physical therapy.

(b) Occupational Therapists (OT) - A qualified OT must be licensed by the Alabama State Board of Occupational Therapy. Services provided must be ordered by a physician for an identified condition(s) noted during the EPSDT screening exam and provided by or under the direct supervision of a qualified occupational therapist. Group occupational therapy is covered only for codes specified as such in the Occupational Therapy Billing Manual. Services are limited to those procedures identified in the Occupational Therapy Billing Manual. Some codes may require attainment of prior authorization before services are rendered. Recreational and leisure type activities such as movies, bowling, skating, etc. are not covered by Medicaid.

1. OT assistants are allowed to assist in the practice of occupational therapy only under the supervision of an OT. OT assistants must have an Associate of Arts degree and must be licensed by the Alabama State Board of Occupational Therapy. Supervision of certified OT assistants must consist of a minimum of one on one on-site supervision at least eight hours per month. Supervision for non certified limited permit holders shall consist of one to one, on-site supervision a minimum of 50% of direct patient time by an OT who holds a current license. Supervising visits must be documented and signed by the OT. The supervising OT must ensure that the assistant is assigned only duties and responsibilities for which the assistant has been specifically educated and which the assistant is qualified to perform.

2. OT aides employed by the OT are allowed to perform only routine duties under the direct, on-site supervision of the OT. Care rendered by an OT aide shall not be held out as and shall not be charged as occupational therapy.

(c) Speech Therapists (ST-Speech Language Pathologist) - A qualified ST must have a Certification of Clinical Competence in Speech Language Pathology or be eligible for certification and licensed by the Alabama Board of Examiners for Speech, Language Pathology and Audiology. Services provided must be ordered by a physician for an identified condition(s) noted during the EPSDT Screening exam and provided by or under the supervision of a qualified speech therapist. Only procedures identified in the Medicaid Speech Therapy Billing Manual are reimbursable.

1. Speech Therapy Assistants must be employed by a Speech Therapist, have a bachelor degree in Speech Pathology and must be registered by the Alabama Board of Speech, Language Pathology and Audiology. Assistants are allowed to provide services commensurate with their education, training and experience only. They may not evaluate speech, language or hearing, interpret measurements of speech language or hearing, make recommendations regarding programming and hearing aid selection, counsel patients or sign test reports, nor other documentation regarding the practice of speech pathology. Assistants must work under the direct supervision of a licensed speech pathologist. Direct supervision requires the physical presence of the licensed speech pathologist in the same facility at all times when the assistant is performing assigned clinical responsibilities. The licensed speech pathologist must document direct observation of at least ten (10%) percent of all clinical services provided by the assistant. Speech therapists may supervise no more than the equivalent of two full-time assistants concurrently.

(d) Services provided under the direction of a health care practitioner provided to Medicaid eligible children by those working under the direction of licensed, enrolled Speech Therapists, Occupational Therapists or Physical Therapists as provided for in this rule must be provided under the following conditions:

1. The person providing the service must meet the minimum qualifications established by State laws and the Agency regulations and be in the employment of the supervising provider;

2. The person providing the service must be identifiable in the case record;

3. The supervising therapist must assume full professional responsibility for services provided and bill for such services;

4. The supervising provider must assure that services are medically necessary and rendered in a medically appropriate manner, and

(e) Podiatrist - Must have a current licensed issued to practice podiatry, and operate within the scope of practice established by the appropriate state's Board of Podiatry.

(f) Chiropractor - Must have a current certification and/or be licensed to practice chiropractic, and operate within the scope of practice established by the state's Board of Chiropractic Examiners.

(g) Psychologist - Must have a doctoral degree from an accredited school or department of Psychology and have a current license to practice as a psychologist, and

operate within the scope of practice as established by the appropriate state's Board of Psychology.

(h) Private Duty Nursing - The services must be prescribed by a physician and rendered by a Registered Nurse or Licensed Practical Nurse employed by a Medicaid private duty nursing provider. Services must be prior authorized and are to be provided in the patient's home. However, recipients eligible for private duty nursing services in the home may qualify for some of these private duty nursing hours when the recipient's normal life activities take them outside the home. To qualify for private duty nursing services, the patient must have a life threatening condition that requires attention around the clock. The constancy of care must exceed the family's ability to care for the recipient without the assistance of at least 4 hours of continuous skilled nursing care.

1. Major commitment on the part of the patient's family and community is mandatory to meet the patient's extraordinary needs. The patient must depend upon family members to provide a support mechanism at home for non-medical care. Specific components include:

(i) The family must have at least one member trained and fully able to care for the patient in the home. In life threatening situations 2 or more trained adults must be available to assure medical safety;

(ii) The family must provide evidence of parental/family involvement, proven capability in performing medical and nursing tasks, and an appropriate home situation (e.g., physical environment, safety, and geographic location for the patient's medical safety);

(iii) A primary care physician must be involved in the development of the recipient care plan prior to admission to the private duty nursing program, be knowledgeable about the plan, and agree to participate by providing primary medical care;

(iv) Essential equipment must either be portable or available at each site that the patient attends; and

(v) Reasonable plans for emergencies (e.g., power and equipment backup for those with life-support devices) and transportation must be established.

2. Criteria - Non-ventilator Dependent Recipients.

(i) High technology non-ventilator dependent patients may qualify for private duty nursing services utilizing any one of the following primary criteria conditions and any one of the following diagnosis criteria. The primary criteria conditions include:

(I) Tracheotomy - Coverage up to 4 months for acute (new) tracheotomy with up to an additional 2 months with documentation of continuing acute problems;

(II) Total Parenteral Nutrition (TPN) - coverage up to 2 months for acute phase with additional certification based upon the need for continuing therapy; and

(III) Intravenous Therapy - coverage up to 2 months for a single episode. The number of hours covered will be a minimum of 4 continuous hours in duration requiring a skilled nurse for monitoring and treatment. Additional hours may

also be approved for secondary criteria conditions listed below in conjunction with the primary criteria conditions.

(ii) A recipient may qualify for private duty nursing services if there is a combination of 2 or more of the following secondary criteria conditions and any one of the following diagnosis criteria.

(I) Decubitus ulcers - coverage for stage three or four ulcers;

(II) Colostomy or ileostomy care - coverage for new or problematic cases;

(III) Suprapubic catheter care - coverage for new or problematic cases; and

(IV) Internal nasogastric or gastrostomy feedings - coverage for new or problematic cases.

(iii) The technology dependence must be related to any of the following diagnoses.

(I) Severe neuromuscular, respiratory, or cardiovascular disease not requiring mechanical ventilator support;

(II) Chronic liver or gastrointestinal disorders with associated nutritional compromise;

(III) Multiple congenital anomalies or malignancies with severe involvement of vital body functions; and

(IV) Serious infections which require prolonged treatment.

3. Criteria-Ventilator Dependent Recipients.

(i) Ventilator dependent patients may qualify for private duty nursing services utilizing any one of the following primary criteria conditions and any one of the following diagnosis criteria. The primary criteria conditions include:

(I) Mechanical ventilatory support is necessary for at least 6 hours per day and attempted weaning is in progress at least weekly;

(II) Frequent ventilator checks are necessary. (Daytime vs nighttime settings, weans, parameter checks, every 2 hours to every shift are dependent on pulmonary complexity.); and

(III) Oxygen supplementation for ventilator dependent recipients at or below an inspired fraction of 40 percent (Fi02 of 0.40).

(ii) The patient must have a related diagnosis requiring ventilator support. These diagnoses include:

(I) Neuromuscular disease involving the respiratory muscles;

(II) Brainstem respiratory center dysfunction;

(III) Severe thoracic cage abnormalities;

(IV) Intrinsic lung disease; and

(V) Lung disease associated with cardiovascular disorders.

4. A care plan must be developed and submitted with each request for service documenting the extensive nursing needs. Careful review of the patient's status and needs should be made by each professional participating in the patient's care. Each discipline should formulate goals and objectives for the patient and develop daily

program components to meet these goals in the home. This plan must include the following:

(i) designation of a home care service coordinator;

(ii) involvement of a primary care physician with specific physician orders for medications, treatments, medical follow-up, and medical tests as appropriate;

(iii) family access to a telephone;

(iv) a plan for monitoring and adjusting the home care plan;

(v) a defined backup system for medical emergencies;

(vi) a plan to meet the educational needs of the patient;

(vii) a clearly shown planned reduction of private duty hours; and

(viii) criteria and procedures for transition from private duty nursing care, when appropriate.

5. Private duty nursing services may be authorized for the following 3 time frames:

(i) A 24 hour per day, 8 week period, generally after discharge from a hospital. After 8 weeks of 24 hour per day nursing, the family and/or caregiver will be responsible for 8 hours of care per day;

(ii) A 16 hour per day, 8 week period, generally after discharge from a hospital or after 8 weeks of 24 hour per day nursing. After 8 weeks of 16 hours per day nursing, the family and/or caregiver will be responsible for 16 hours of care per day; and

(iii) An 8 hour per day, 8 week period, generally after discharge from a hospital or after 8 weeks of 16 hours per day nursing. After 8 weeks of 8 hours per day nursing, the family and/or caregiver will be responsible for 20 hours of care per day.

6. At each certification, the care plan will be denied, approved, or additional information will be requested. The patient should be transitioned to the most appropriate care when the patient no longer meets the private duty nursing criteria. The most appropriate care may be home care services, nursing home placement, or the Home and Community Based Waiver Program.

7. Cost Effectiveness: The cost of private duty nursing services, when combined with the total daily cost of all Medicaid reimbursable services, should not exceed the cost of available hospital care for which the recipient would qualify if private duty nursing services were not provided.

8. Private duty nursing providers are required to indicate the date and time of all services provided on a signature log maintained in the patient's record with a copy retained by the patient/parent or guardian. The nurse providing services and the caregiver must sign each entry.

9. Private duty nursing providers are required to submit to Medicaid a copy of the Home Health Certification and Plan of Care form (HCFA-485), the Medical Update and Patient Information form (HCFA-486), the Private Duty Nursing Acceptance Form (Form 166), and the EPSDT Referral for Services form (Form 167) for Medicaid to consider authorization for services.

10. Private duty nursing providers are required to submit the Home Health Certification and Plan of Care form (HCFA-485) and the Medical Update and

Patient Information form (HCFA-486) to Medicaid for continued services at least fourteen (14) days prior to the recertification due date.

11. Non-Covered private duty nursing services include the following:

(i) When it is determined that the patient does not meet the medical and diagnosis criteria and/or does not require at least 4 consecutive hours of continuous skilled nursing care per day;

(ii) Behavioral or eating disorders, observational care, or monitoring medical conditions which do not require medically necessary intervention by skilled nursing personnel;

(iii) Services that were not prescribed to treat or ameliorate a condition identified as a result of an EPSDT screening. The conditions identified must meet the required medical and diagnosis criteria;

(iv) Custodial, sitter, and respite services;

(v) Services after the recipient is admitted to a hospital or a nursing facility; or

(vi) Services after the recipient is no longer eligible for Medicaid.

12. Failure by the provider to comply with agency rules and program policies contained in the applicable Private Duty Nursing Services Program Manual may result in recoupments and termination of the provider contract.

(i) Air Ambulance - Refer to Rule 560-X-18-. 15.

(j) Environmental Lead Investigators - a qualified investigator must have graduated from a four-year college or university with a minimum of 30 semester hours or 45 quarter hours of combined course work in biology, chemistry, environmental science, mathematics, physical science, or a minimum of, or evidence of, five years or more of permanent employment in an environmental health field. Any person employed must have successfully completed the training program for environmentalist conducted by the Alabama Department of Public Health before being certified by the Alabama Department of Public Health.

1. Environmental Lead Investigations are billable as a unit of service. A unit of service is the investigation of the home or primary residence of an EPSDT eligible child who has an elevated blood lead level. Testing of substances which must be sent off-site for analysis, or any non-medical activities such as removal or abatement of lead sources, or relocation efforts are not billable as part of an Environmental Lead Investigation.

Author: Ginger Collum, Program Manager, Clinic/Ancillary Services, Medical Services Division.
Statutory Authority: State Plan, Attachment 3.1-A; 42 CFR Section 440.110, Section 441.56(2)(c); Omnibus Budget Reconciliation Act of 1989.
History: Rule effective October 1, 1982, September 11, 1992, January 11, 1994, September 13, 1994, September 12, 1995, August 14, 1996, November 14, 1996, and May 10, 1999. **Amended:** Filed October 19, 2001; effective January 16, 2002.